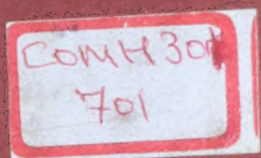


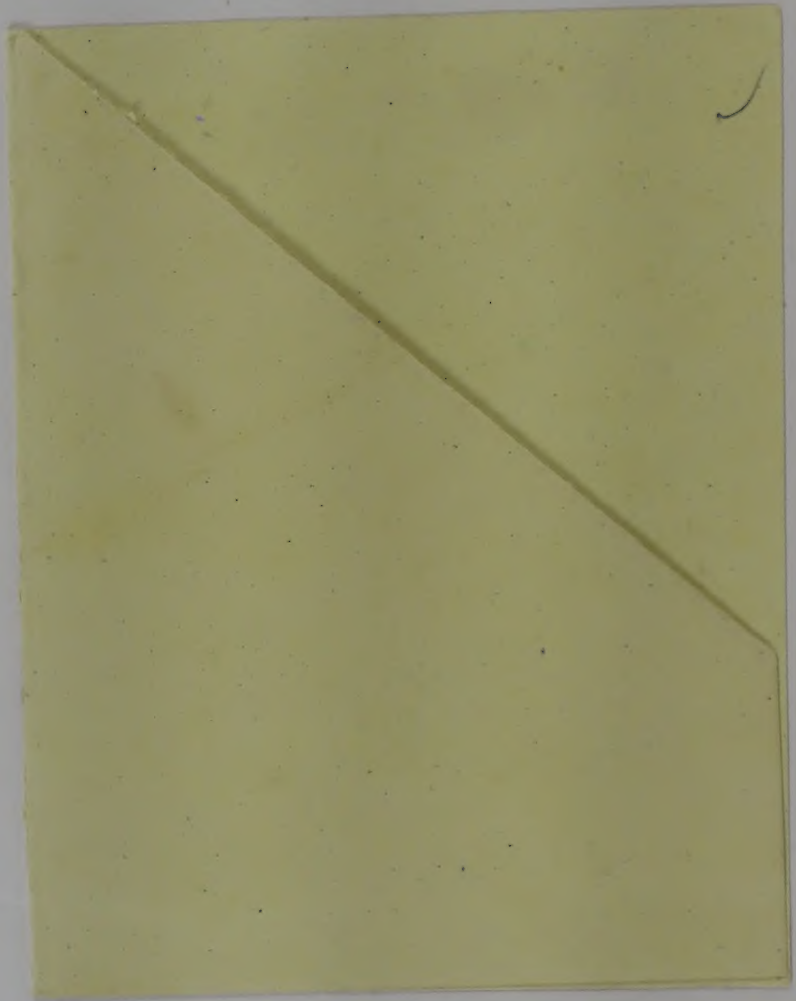
Health care in the Third World

A new policy for VSO



Voluntary Service Overseas
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*'Go to the people,
live among them,
love them,
start with what they know,
build on what they have.
But of the best leaders
when their task is accomplished,
their work is done,
the people all remark
we have done it ourselves.'*

Ancient Chinese poem

This paper is intended to be the focus of a discussion of the causes of ill health in the Third World and of the most appropriate roles that medical and paramedical volunteers can play within the framework of VSO.

What is the *raison d'être* of VSO? Surely one primary purpose is to provide a channel whereby people can participate in bettering the lot of the poorest sections of the populations in the Third World. To begin to do this one must consider the fundamental question: 'Why are these people poor?'

In every field in which VSO operates, it must have its own analysis regarding the processes at work creating and maintaining poverty in the Third World and allow this analysis substantially to influence its judgement concerning the placement of volunteers.

Ill health in the Third World is only one symptom of the enormous disease of poverty and therefore cannot and must not be taken out of context, or considered in isolation. The health problems must be seen in an overall perspective and VSO's medical programme planned accordingly. Having worked out our own analysis of the situation and given that we receive a wide range of differing types of request from Third World countries, we must neither impose our own ideas where they are not acceptable, nor fill volunteer projects which compromise our own criteria. Efforts should be concentrated on seeking mutually compatible aims and objectives.

HEALTH PROBLEMS IN THIRD WORLD COUNTRIES

The common illnesses of Third World countries have been persistently and repeatedly referred to as 'tropical diseases'. Though some pathogenic micro-organisms do require a tropical climate to exist, most morbidity and mortality in the developing world results from diseases caused or made worse by the prevailing poverty, not the climate. Indeed, far from being 'tropical' the disease spectrum of a typical Third World country today is almost exactly mirrored by that which occurred in 19th century Europe. The vast bulk of these diseases falls under two main headings:

- (a) Malnutrition
- (b) Communicable diseases

Malnutrition includes the well-known gross clinical syndromes marasmus and kwashiorkor. Both of these conditions are a consequence of inadequate intake of protein and calories, interacting with infections (such as measles or gastro-enteritis). Though not as obvious as these, there is a much more widespread problem of undernutrition which, among other things, reduces the resistance of an individual to infectious diseases.

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...contributing cause of ...umented. For example, it ...erved that, except where populations are malnourished or otherwise uncommonly susceptible to disease, the incidence of tuberculosis is significantly lower than would be expected by the widespread presence of the tubercle bacillus.

Similarly, it has been observed that mortality due to measles was 274 times as high in Ecuador as in the United States in 1960-61 *before* the development of measles immunisation. At the time of the study, the incidence of the disease in the two countries was probably not significantly different. A more recent study of Recife, Brazil, identified nutritional deficiencies in 74% of measles deaths¹.

Vitamin deficiencies cause diseases such as xerophthalmia (leading to blindness), rickets, beri-beri and pellagra.

Communicable diseases include any disease which can be passed on from one person to another, sometimes by direct contact, sometimes through air or water and sometimes by means of an animal or insect vector. The most frequently occurring and widespread diseases in this group include the diarrhoeas and dysenteries, pneumonia, measles, tuberculosis, leprosy, malaria, hookworm, schistosomiasis, filariasis and so on. In Tanzania, for example, infective and parasitic diseases constitute roughly one-third of all hospital mortality as well as morbidity. Diseases of the respiratory system account for one-fifth of all mortality and one-tenth of the morbidity, while diseases relating to nutrition account for approximately one-tenth of all deaths and almost as high a percentage of hospital admissions. Finally, the fourth highest cause of death in hospital relates to diseases of the digestive system, accounting for just under one-tenth of all mortality and morbidity².

In all, these four poverty-linked disease groups account for *three-quarters* of all hospital deaths.

As previously mentioned, this pattern of disease was also seen in 19th century Europe. Not only did the epidemics of plague, cholera and typhoid cause major catastrophies, but perhaps less well-known is the high incidence of kwashiorkor that occurred in the Irish famines, and the presence of leprosy and malaria in many European communities.

In contrast to this picture, the diseases which today in the developed countries cause by far the largest proportion of deaths, namely heart disease, strokes and malignancies, form a very small proportion of the total in the Third World. In Tanzania, for example, heart disease constitutes less than 4% and cancers 5%² and in Papua New Guinea 0.9% and 4.7% of the total respectively³.

POPULATION PYRAMIDS

In most developing countries the structure of the population is entirely different from that in the more developed countries. In the former, the population under 15 years of age takes up 40-45% of the total as compared with approximately 15% in the latter. Approximately one-half of all deaths occur in the under 5 age group. The infant mortality rate, the best overall indicator of the health status of a population, is anything up to 300 per 1000 live births in Third World countries as opposed to 16 per 1000 live births in the United Kingdom. Therefore it can be seen that the burden of morbidity and mortality falls upon the babies and young children, but women of childbearing age follow close behind.

The underlying causes, plus the factors which aggravate and facilitate the transmission of the diseases discussed above include: lack of plentiful water supply, poor diet, inadequate or overcrowded housing, inefficient or absent waste disposal systems, poor hygiene, high fertility, low literacy and unemployment.

Lack of a piped water supply to people's homes leads to far smaller quantities of water being used than would be necessary to prevent a whole range of diseases, including the diarrhoeal/dysentery group and many skin infections. Lack of proper sanitation allows insect vectors, such as mosquitoes and flies, to breed, increasing the incidence of diseases such as malaria and trachoma. Poor sewage disposal encourages the spread of parasites such as hookworm.

In any given country the percentage of the population which has access to a water supply and sewage disposal system is directly related to the per capita income of that country. In countries with a GNP per capita of less than \$250 (US) per annum (1976), only 25% of the populations have access to safe water⁴.

Crowded living quarters promote the spread of diseases such as tuberculosis, leprosy, measles and whooping cough. High fertility means too many children in quick succession, leading to anaemia and exhaustion in the mothers and malnutrition in the infants. Low literacy renders the spread of health education more difficult and so on. The list is endless.

When one starts asking the question 'What are the root causes of this poverty?' many varying replies are received. There are no straightforward answers and the factors vary in each and every country. However, I feel that David Werner has summed up most situations very succinctly in a recent paper⁵ when he states: 'In Latin America, as in many other parts of the world, poor nutrition, poor hygiene, low literacy and high fertility help account for the high morbidity and mortality of the impoverished masses. But as we all know, the underlying cause — or more exactly the primary disease — is inequity: inequity of wealth, of land, of educational opportunity, of political representation and of basic human rights. Such inequities undermine the capacity of the peasantry for self-care. As a result the political/economic powers that be assume an increasingly paternalistic stand, under which the rural poor become the politically voiceless recipients of both aid and exploitation. In spite of national, foreign and international gestures at aid and development, the rich continue to grow richer and the poor poorer.'

Poor health, as we have already discussed, is a symptom of poverty and the health status of a population will ultimately depend far more on the decisions of the people in power than the mere multiplication of preventive and curative health institutions. Nevertheless, in the field of health services as well as in others, the more equitable distribution of available resources would certainly be a step in the right direction. Perhaps this can most easily be appreciated by considering again the specific area of health care in developing countries.

HEALTH CARE SYSTEMS IN DEVELOPING COUNTRIES

In most developing countries, health care systems are ones that have been inherited in toto from the West. There is a growing awareness that the Western health care systems are:

- 1 Inequitable in their distribution of resources
- 2 Perpetuating a system of dependency
- 3 Inappropriate for the disease problems and population structure in developing countries.

Although three-quarters of the population in most developing countries live in rural areas, three-quarters of the spending on medical care is in urban areas, where three-quarters of the doctors live. Three-quarters of the deaths are caused by conditions that can be prevented at low cost but three-quarters of the medical budget is spent on curative services, many of them provided for the elite at high cost⁶.

Who generally has the most influence on the decision as to how a health budget is spent? In the final analysis in most countries it is the medical profession, by and large trained after the Western model, who bring the most pressure to bear on ministries of health. This has often resulted in Western style teaching hospitals, district hospitals and so on, being provided for the few to the detriment of the majority. In some countries, the one teaching hospital in the capital city absorbs up to 60% (in running costs) of the total annual health budget.

The rationale for spending such enormous proportions of available funds on so few institutions usually goes as follows:

- 1 The institutions are to be 'centres of excellence' where the most up-to-date and finest health care should be practised as a model to which to aspire and where the future generations of health workers will be trained.
- 2 They should act as 'referral centres' at the peak of the health care pyramid, and will receive cases from all over the country which are too complicated to be dealt with at a sub-centre.
- 3 They should be centres for medical research.

Sadly, these ideals have not worked out in practice, and the overall result has been the channelling of resources into a costly, inappropriate and unfair system of health care delivery.

Referral centres

In Ghana it is estimated that fully two-thirds of the population are not effectively covered by government curative health services⁷.

In Dar-es-Salaam 93% of the in-patients at the university teaching hospital were found to be from a 15km radius of the hospital⁸.

In Uganda, the average number of out-patient attendances per person halves every 2.6km from a dispensary and every 1.6km from an aid post⁹.

In India, in one survey, it was found that 87% of the attendance at primary health centres was from villages within a radius of 6.4km¹⁰.

These examples serve to illustrate the fact that in developing countries the utilization of any type of health care institution is directly related to the distance a patient must travel to reach it.

One large hospital, however 'excellent', will never act as the peak of a referral system as intended, but will cater for the needs of those people in its immediate vicinity.

An analysis of the conditions suffered by patients in teaching

hospitals in various Third World countries has shown that, far from the rarer or more complicated diseases, the vast majority of patients who inundate the available bed space are suffering from illnesses directly related to the nutritional and communicable disease categories discussed earlier, i.e. diseases which can be effectively prevented at source by simple public health measures, and would virtually be eradicated by an increase in the socio-economic status of the majority of populations.

Centres of excellence

A short example, but one which is seen repeatedly in the Third World, will serve to illustrate the inappropriateness of the approach to health care in a Western-style hospital:

A mother had an undernourished infant suffering from severe diarrhoea, causing dehydration and threatening survival. She took the child many miles to the nearest hospital where it was admitted to the paediatric ward and resuscitated with intravenous infusions and drugs prescribed and administered by highly qualified professionals. The child's progress was monitored by blood investigations performed in a well equipped laboratory and by X-rays and the child was eventually delivered back to the mother, 'cured' — at least for the time being. The mother, who found herself in a totally alien and rather frightening environment, was a non-participant in the return to health of her child. However, the child did not die, as so many others had done, and thus she spread the good news that the hospital indeed appeared to be the way back to health for children with this affliction.

However, it has already been clearly demonstrated (for example in Nigeria and Papua New Guinea) that with simple and easily carried out instructions, any mother can rehydrate a child suffering from gastro-enteritis in her own home. In Papua New Guinea, in one survey, it was found that even in severe cases of gastro-enteritis a 99% survival rate was achieved by this method. Not only is hospital treatment costly, time consuming and available to only a tiny minority but, more seriously, the emphasis on a hospital-based service will tend to remove the option of home treatment from the non-professionals and undermine the confidence of these people to deal with this type of problem effectively themselves. It also reinforces the notion that the curative approach is the all important one and diverts attention away from more fundamental issues (in this case principally those of an available water supply, sanitation and malnutrition) which have to be tackled to prevent the diarrhoea in the first place.

This is just one example of the 'sledge-hammer to crack a nut' approach to the management of common, preventable illnesses in many Third World countries. When the majority of diseases can be (a) easily prevented — by better housing, sanitation, nutrition, etc., and (b) easily treated by paramedics or non-professionals, it can be clearly appreciated that the Western-style approach to health care, is at the very least, a squandering of precious resources.

Mention should be made at this point of the provision of radiotherapy units in the major hospitals of some countries. When one considers that perhaps 5% of mortality in a developing country may be due to cancers, of which only a small proportion will be suitable for radiotherapy treatment, the existence of these units would not seem to be cost-effective. They would appear to satisfy the professional aspirations of doctors rather than to benefit the health of the rest of the population.

The consequence of training health workers in a 'centre of excellence' is that they are in general unprepared to cope with the actual health problems of their country upon

qualification. So, disillusioned, they remain in the urban areas competing for private patients, or emigrate in search of higher qualifications and rewards. 'The training abroad of clinical specialists has often served to increase the status of sophisticated hospital services, and has almost certainly helped to divert both funds and manpower from an extension of the coverage by health services.'¹¹

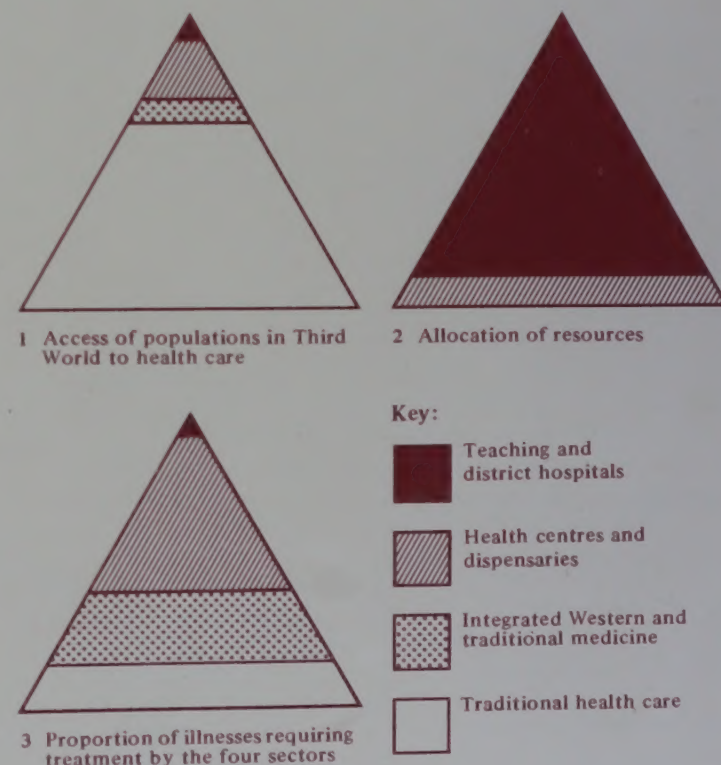
The health workers that do work in the rural areas often do not identify with the local communities, nor do they feel answerable to them.

To attempt to put the cost of 'centres of excellence' in perspective, consider the following:

In general terms:

- 1 For the cost of providing four beds in a teaching hospital (in Africa) a health centre can be built which can cater for the health needs of around 20,000 people.
- 2 The cost of taking a single chest X-ray is equivalent to the total budget available in most Third World countries for the health care of one person per year.
- 3 For the cost of providing one day's physiotherapy in a teaching hospital for a child crippled by polio, 300 children could be immunized against the disease.

As a pictorial guide, the following diagrams may help to illustrate some of the preceding points.



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DEPENDENCY

This has already been touched upon in the illustration of the child with gastro-enteritis.

The phenomenon of dependency on the medical professionals for maintenance of health as well as the cure of disease is first and foremost illustrated in Western society. Note the increase in the demand for regular medical check-ups and the inundation of the health service by patients suffering from self-limiting, home-treatable illnesses.

Related to the problem of dependency on the medical professionals is the fact that much of current medical practice in the West, which up till now has been taken for granted as being effective, is now being more critically evaluated. Many well-established therapeutic regimes (e.g. the management of patients with coronaries in intensive care units, hospital deliveries and various drug therapies) are being discovered to be of questionable value. Some have already proved to be at best useless, and at worst dangerous. Although life expectancy in developed countries has risen 15 years this century, the increase is almost entirely due to reduced mortality under the age of 40 years. So, a 40-year old person in 1900 had approximately the same life expectancy as a 40 year old now. The huge expenditure on curative medicine in adults has clearly achieved very little. In addition, much research has indicated that in the under 40 age group improved nutrition, housing, sanitation and work environment have been much more significant in reducing the mortality than curative medicine.

The dependency upon the Western system of medicine (and upon the health professionals) which has appeared in the developing world is regrettable, and systems of traditional medicine may well be just as effective (or ineffective) and certainly more acceptable in the eyes of their users. On the subject of traditional practice, it must be remembered that in the United Kingdom approximately 50% of all first line medical care and advice is given by 'traditional practitioners', i.e. lay people who can lend an experienced and sympathetic ear.

In developing countries, approaching 100% of the population will seek advice in health matters from a traditional practitioner in the first instance.

SOME ANSWERS?

'Behind the training of doctors is the assumption that health care must be based on the availability of professionals with up to 20 years of basic schooling and medical education, which then can become the basis for many more years of specialist training. These assumptions are held despite the knowledge that throughout the world most illness and mortality do not require the attention of highly trained doctors.'¹²

PRIMARY HEALTH WORKERS

Much has already been written about the rôle of the medical auxiliary in developing countries. Primary health workers are usually locally trained people providing preventive, educational and simple curative health care, often on a part-time basis, to

the community they are part of and by whom they have been chosen. It has been estimated that a well-trained and well-motivated primary health worker can adequately cope with up to 97% of health problems that he encounters, leaving the remaining 3% to be referred onwards. Aspects of environmental, agricultural and community development work are incorporated into these programmes, which have arisen as a result of local initiatives in more than 100 countries.

A brief look at comparative costs for the training and salaries of various categories of health worker will indicate the cost-effectiveness of medical auxiliaries¹³.

Category of worker	Professional	Auxiliaries		Community health worker
	eg doctor, nurse	Senior health worker eg medical assistant (E. Africa)	Junior health worker eg health post orderly	eg village health worker
Cost of * Training	100	5	2.5	1
Cost of * Salaries	100	50	25	10 or less

* Approximate average cost of training/salaries where professional = 100.

Costs will of course vary from one country to another but to take one example:

In 1974/75 in Tanzania the costs to educate and train:

One doctor	£14,700
One medical assistant	£ 880
One rural medical aide	£ 425

One can train 8 medical assistants plus 16 rural medical aides for the price of one doctor. However, the pitfall which must be avoided at all costs is to render the health centre/primary health worker system a mere extension of the Western style hospital system. David Werner has neatly summed this up in his description of community-supportive and community-oppressive health programmes.

'Community-supportive programmes are those which favourably influence the long-range welfare of the community, that help it stand on its own feet, that genuinely encourage responsibility, initiative, decision-making and self-reliance at the community level, that build upon human dignity.

Community-oppressive programmes are those which, while invariably giving lip service to the above aspects of community input, are fundamentally authoritarian, paternalistic or are structured and carried out in such a way that they effectively encourage greater dependency, servility and unquestioning acceptance of outside regulations and decisions, those which in the long run are crippling to the dynamics of the community.'¹⁴

In other words, a programme of the wrong sort, even though it involves the use of health centres, medical auxiliaries and so on, has a potential for being just as oppressive and damaging as one based on the hospital/health professional axis.

The most recent advances have involved the use of the 'village health worker' as the chief agent of primary health care. This is essentially a part time health worker elected by his or her own community rather than appointed from outside. In

places where village health workers are active there is growing evidence that genuine community involvement in health care is taking place, and that a greater commitment is obtained from this type of health worker.

SUMMARY

- 1 Disease patterns in Third World countries are, by and large, consequent upon the poverty that the vast majority of the people suffer, not the climate in which they live.
- 2 The main bulk of illness falls into two categories: nutritional deficiencies and communicable diseases.
- 3 These diseases would virtually disappear if populations had proper access to land, employment, adequate housing, water supply, sanitation and education.
- 4 Health care systems in operation in the Third World are often:
 - (a) unfairly distributed
 - (b) tending to perpetuate dependency
 - (c) inappropriate for the disease patterns and population structures of the countries.

They simply reflect one end result of the processes operating within countries and internationally which have led to the present inequitable state of affairs.

Some parts of these health care systems, exported by the Western world, are beginning to be shown to be of questionable value anyway.

The worldwide move is now towards primary health care but even this has to be approached with caution to avoid further pitfalls. This approach is regrettable if it merely serves to paper over the cracks and obscures the real reasons behind disease and death in the Third World.

IMPLICATIONS FOR VSO

In the light of this summary, what are the implications for VSO's medical programme?

Objectives

The first priority must be to select, train and offer overseas volunteers who in addition to the personal and professional qualities which VSO has always sought, have, or can reasonably be expected to develop, an awareness of the political, social and economic factors contributing to the pattern of ill-health in Third World countries. If they are able to pose questions in their own minds; to view health problems in a wider perspective than their standard Western training will have given them; to realise that the delivery of health care has a very small part to play in improving health — then there is a chance that they will be able to catalyse whatever communities they work in to start asking the same questions, and eventually to become aware of the factors which have led to their condition. In addition, if they can go overseas with an understanding of the inadequacies and inappropriateness of our own health care system, this would in a very small way help to slow down, hopefully, its continued replication.

Secondly, VSO should be supporting projects which are involved in the promotion of more equitable, more appropriate systems of health care: where possible, those that are springing from the initiatives of the less-privileged themselves rather than supplied from above or outside. In general, this would mean continuing the move towards involvement in rural rather than urban projects (unless the latter are based in slum or shanty-town areas, or are involved in certain types of research — see below). It would mean sometimes supporting the activities of minority groups. It would mean backing low-cost systems such as health centres rather than hospitals, training village health workers rather than nurses or pharmacists. It would mean participating in on-going health education, public health and immunisation programmes, helping to introduce ideas of appropriate technology and respecting and sometimes supporting or working alongside the practice of traditional medicine.

It could mean providing volunteers for appropriate research programmes (for example in the development of heat stable vaccines, or evaluation of the effectiveness of health interventions). Above all, it would mean seeking out health programmes which are initiated and supported by local communities, which involve finding people's own solutions to problems which they have identified; which may incorporate traditional medical practice and which help to break down the rigid barriers and professional mystique which forms part of the Western health care system.

Projects supported

VSO already has an approved list of project selection criteria (see inside back cover) which are used worldwide for the whole spread of projects to which it sends volunteers. This paper is intended to show in greater detail how they should be applied in the health sector.

Various projects in which VSO has already been involved not only meet the project selection criteria but also go some way towards meeting the objectives outlined in this paper. Some examples of these projects are now briefly illustrated.

Community-based Health Programme, south Philippines

This programme began with the election of people from the barrios (villages) to become community health workers who were then trained in the basic recognition and treatment of common illnesses, plus nutrition, sanitation and family planning. Much of the time was spent in discussion to ensure that the whole community was involved and supported the scheme. In some of the barrios, people began to look more closely at the other problems they were experiencing and began to see the answers in terms of a community-solving process rather than on an individual level. The volunteer in this project lived in each barrio for periods of up to two months in order to be able to take part in the process.

Gonoshasthaya Kendra (People's Health Centre) Bangladesh

This venture was started by Dr Zaffrulla Chowdhury in 1972 and now involves a network of small health centres in the surrounding villages staffed by paramedical workers who are also trained at the project. The workers are elected by the villagers themselves, and are trained for six months in basic health care. The project also runs a primary school, carries out agricultural work, has a workshop (training men and women in such skills as welding) and a jute crafts workshop. Volunteers have been involved in the medical and technical side of this project.

Chipata Nutrition Group, Zambia

The aim of this group is to activate and encourage the local population to become aware of the many problems associated with nutrition and then to work out ways of combatting them which are suitable and appropriate to the locale. The policy controlling body of the group is a locally elected committee (open to anyone) with no interference from outside so that it can be very responsive to local needs and conditions. The group's activities divide themselves into three areas, namely formal and non-formal education and the provision of low-cost foodstuffs. The former include residential courses for mothers and their malnourished children, the establishment and running of nutrition clubs in the local primary schools and follow-up work in the villages.

Tuitai Health Centre, Bangladesh

This project is in a remote and isolated area south of Dacca, in a place where there are no other health programmes in operation. The clinic itself is simple, built out of bamboo and reeds with a corrugated iron roof. Water is supplied from a tube well but there is no electricity. Girls from Tuitai village are at present working in the health centre and the volunteer's rôle is in the training of these to eventually take over. This is very much a project run by the village and all major decisions have to go to the village committee. The project was initially started by two Roman Catholic sisters.

Kamlapur Clinic, Dacca, Bangladesh

The clinic is situated next to Dacca's main railway station and consists of two small floors over a warehouse. The clinic has seventy beds and equipment is very basic. The background of the patients is that they are destitute: some live outside around the railway station; others come in from villages and other parts of Dacca. Some are found on the street by the staff, and are treated and fed for nothing. The clinic is run by an English doctor, with the help of a Bengali part-time doctor, a volunteer nurse and eight paramedical staff. The clinic, though in an impoverished area of the city is only a stone's throw from Dacca's main commercial area. Its existence is an example of the wide inequalities of the distribution of wealth and facilities in the city.

Nutrition projects in Papua New Guinea

Though strictly falling outside the policy guidelines, these posts (as Provincial Nutritionists concerned with the promotion, organisation and administration of the nutrition plans in each Province) are part of a health policy of a government which sees the solutions to malnutrition in the context of socio-economic development, and which perceives the nutrition programmes as only having one part to play in this.

Projects sought

Field Officers and others have been positively invited to seek projects of this kind relating clearly to the very poor, attacking the roots of ill health rather than the symptoms, and with people participant rather than simply recipient in their own health care.

It may be remarked that the mainstream government or mission hospital or health centre is conspicuously absent from the six projects illustrated above. Clearly requests will continue to emanate from a spectrum with the high technology/teaching hospital type at one end and the

community-based integrated project at the other. The typical mission-hospital plus Maternal and Child Health (MCH) clinic request falls somewhere between these extremes.

VSO has asked its Field Officers and others to seek and recommend projects at the community-based end of that spectrum. Requests of the high technology/teaching hospital type will not be agreed, nor those from district level hospitals. But VSO will continue, at this stage, to find acceptable in principle requests coming from small hospitals and health centres of about 100 beds or less where there is evidence of extension work or the training of paramedical staff and it is in this context that a number of the kind of mission hospital plus MCH requests will continue to be agreed. Their structure may not allow these institutions fully to reflect the principles advocated in this paper (and their requests will not be met at the expense of more pioneering projects) but they will be moving towards those principles, and the presence of a volunteer should assist that process.

The above paragraphs have been deliberately prescriptive, for VSO wishes to see volunteers deployed in the ways discussed. Nonetheless the right of a Field Officer to argue a special case outside these guidelines is fully respected, as is the right of serving volunteers to influence VSO policy and to argue refinements or amendments to strategies recommended in this paper if they so wish.

Recruitment

Given that we aim to participate in well-researched and documented projects of the kind discussed in earlier paragraphs of this paper, recruitment must be re-focused and strengthened so that there is a sufficient flow of medical volunteers from backgrounds appropriate to the kinds of project we envisage supporting and also so that VSO does not induce applications from people whom it cannot then place.

Those such as nurse midwives, nutritionists and community physicians have training and experience likely to be susceptible to adaptation for the kind of projects we envisage supporting, and active recruitment of these categories will be continued and indeed strengthened. In addition new avenues for recruitment and placement of public health inspectors, experienced state enrolled nurses, health visitors and nurse tutors will be investigated.

On the other hand there are professional categories so dependent on sophisticated institutions and equipment, or so likely to perpetuate the diverting of scarce resources into high technology treatment for the few, that they are never likely to be requested by the kind of projects VSO wishes to support. These categories include specialised doctors such as neurosurgeons, radiotherapists, pathologists and ophthalmologists, radiographers, and specialised medical laboratory technicians. Specific recruitment in these categories will cease. However, in one or two exceptional cases people with these qualifications might be considered for posts involving the training of paramedical workers overseas.

A third group falls roughly in between those two extremes. This includes pharmacists, dentists, general medical laboratory technicians, physiotherapists and other remedial therapists and some doctors. These will be actively recruited where acceptable projects have been identified. Inevitably many requests in these categories will have to be resisted because they relate to the sophisticated high technology type of earlier discussion. But it is hoped that Field Officers will increasingly be able to identify projects allowing such volunteers to escape the normal high cost trappings of their work — for example physiotherapists to teach village mothers

how to cope with their own crippled children, occupational therapists to help set up small local industries or craft centres, or pharmacists to train primary health workers in diagnosis and treatment of common diseases.

IMPLEMENTATION OF VSO POLICY

Action is in progress now both in Britain and overseas to ensure the fullest possible implementation of VSO medical policy.

Among the measures being taken are:

In Britain:

major new recruitment drives for the volunteers most needed

new efforts to involve all relevant people in VSO thinking on medical policy and its further evolution – including the twice-yearly production of a medical newsletter

extension of volunteer training, through additional weekend courses and extended professional briefing courses

Overseas:

Analysis at national level:

Field Officers will make an assessment of what provision the government's most recent health planning document makes for rural health extension, and village health worker training. They will foster good relationships with officials responsible for these sectors which should lead to the identification of appropriate volunteer rôles. Field Officers will liaise with the World Health Organisation office and note WHO guidelines, outlined in its publication 'Health by the People'.

Indigenous non-government organisations:

Some of these may be breaking new ground, or seriously trying to involve their members in community-based health schemes: among those with which relationships could usefully be established are village committees, shanty-town community groups, peasant organisations, co-operatives, women's interest groups, organisations of traditional midwives, mission groups, and farmers' clubs.

Volunteers and other aid personnel:

Volunteers – and not only those who are working in the health sector – are often able to advise Field Officers of such schemes operative in their districts, and regular liaison with other aid personnel may serve the same end.

There are parts of the indigenous health services of the Third World which are concerned with the really poor, and which may be run by the poor themselves, and which perhaps are demonstrating simple health care of a kind which could in time be replicated in many other places. There are undoubtedly occasions where a volunteer can properly be used in such contexts. Meanwhile the many and articulate requests from the more privileged sectors will be resisted.

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NOTES

1. Health Sector Policy Paper: World Bank 1975.
2. Doctor Auxiliaries in Tanzania: Oscar Gish, The Lancet 1.12.73
3. Papua New Guinea Five Year Health Plan.
4. World Development Report, August 1978 (World Bank).
5. The Village Health Worker – Lackey or Liberator 1977.
6. David Morley – Paediatric Priorities in the Developing World.
- 7, 8 and 9. Health Planning in Developing Countries, Oscar Gish.
10. WHO, 1973.
11. World Bank, 1975.
12. O. Gish & M. Godfrey, New Society 17.3.77.
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VSO PROJECT CRITERIA

VSO now expects everyone associated with its programmes to evaluate jobs against the six points listed below. In all normal circumstances it will want to be persuaded that a job satisfactorily meets all of them.

1 Purpose

The job aims, directly or indirectly, to change and improve the circumstances of some of the poor and disadvantaged, in ways and styles determined by communities and governments in the Third World. Its benefits will not accrue only to a small minority wishing to maintain a privileged position.

2 Local manpower

The use of a volunteer will not discourage or prevent one of the receiving country's own people, willing and able to do the job, from so doing. If the country has available its own people qualified but not willing to undertake the job, the deployment of a volunteer will require special justification.

3 Training

Either the volunteer will be in a position to pass on his skills whether formally or less formally to nationals of the country; or the receiving country will have other training policies ensuring that eventually many more of its own people will be doing the kind of work for the time being undertaken by the volunteer. Hence, one way or another, the job will at some future date no longer need a volunteer.

4 Expatriate salaried manpower

Where a job has the funds and opportunity to recruit on fully salaried terms, a volunteer will not be provided merely as a financial expedient, but only where there are further and positive reasons for the request.

5 Management and support

The job will need full-time attention over the ensuing two years, and is likely to operate with enough efficiency, and with adequate support, to enable a volunteer to be effective.

6 Community

There is in one form or another an indigenous community with which the volunteer can identify, and with which he or she may be able to spend much of his or her leisure, giving the opportunity for understanding and friendships to develop.

